

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006616

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 6002 Registrar's No. 1318 STATE FILE NUMBER

**FILED MAR 15 1963**

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Rev. 4/59

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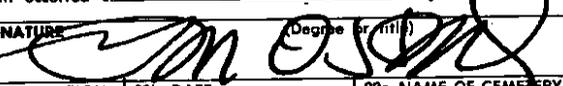
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SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in lb <b>15 YEARS</b>		c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>RESEARCH HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3027 BALTIMORE AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ROSS HAYES</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 24<sup>th</sup> 1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KNOX, COUNTY TENN.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>NEWTON J. HAYES</b>		13b. MOTHER'S MAIDEN NAME <b>HARRIET HOY</b>	14. NAME OF HUSBAND OR WIFE <b>BERTHA HAYES</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>NO</b>		16. SOCIAL SECURITY NO. <b>2</b>	17. INFORMANT <b>Mrs. BERTHA HAYES</b> Address <b>3027 BALTIMORE AVENUE KANSAS CITY, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure &amp; uremia</b> DUE TO (b) <b>arteriosclerosis - advanced -</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>YRS -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>agranulocytosis -</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year <b>None</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>10 yrs</b> to <b>2-24-63</b> and last saw her/him alive on <b>2-24-63</b> . Death occurred at <b>9:25 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE  (Degree or title)		22b. ADDRESS <b>104 P. V. MEDICAL BLDG. 71ST AT TOMPKINS</b>	22c. DATE SIGNED <b>2-25-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 27, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b> 23d. LOCATION (City, town, or county) <b>PRairie Village, Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>DW Newcomer's Sons</b> ADDRESS <b>1831 BRUSH CREEK BLVD KANSAS CITY, MO</b>		25. DATE RECD. BY LOCAL REG. <b>2-27-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Eugene Osgood M.D.  
P.R.H.I.E. Dillage Medical Bldg - 69th & Mission Road  
2:00 - 5:30  
W 0 - 14  
R R

8-2-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leneb. Michael

Licensed Embalmer No. 4340

P. O. Address K.C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.